PRINTED: 11/08/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY COMPLETED 10/15/2024	
	PROVIDER OR SUPPLIE NSTER VILLAGE I			2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Home Complaint I Complaint IN0044 related to the allega Survey dates: Octo Facility number: 0 Provider number: 100 Census Bed Type: SNF/NF: 52 Residential: 83 Total: 135 Census Payor Type Medicare: 7 Medicaid: 35 Other: 10 Total: 52 This deficiency ref accordance with 41	2568 - Federal/State deficiency ations is cited at F842.  Ober 11 and 15, 2024  00100 155191 266130  E.:	F 00	000	Please accept this plan of correction as our credible allegation of compliance. The facility respectfully requests desk review to determine compliance.  The filing of this plan of correction does not constitute that the alleged deficiency districted in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  Plan of Correction F 842  I. Action taken for those residents identified: Resident B and C. Resident C meal consumptions are being documented and audited. C.N and Nursing staff have been re-educated to document mea consumption. Resident C no longer resides at Westminster Resident B and C did not experience any adverse reactiful. How other residents a identified: An audit of residents' meal documentation was completed.	a  te id  ce  C's  N.A.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/23/24 for documentation of meal consumptions. Any issues identified of records lacking documentation of the meal consumption were addressed if

TITLE

Beverly Dell 10/25/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000100 If continuation sheet

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
I I		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155191	B. WI	NG		10/15/2024		
		-	•	STREET.	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R		2210 G	REENTREE N			
WESTMI	NSTER VILLAGE H	KENTUCKIANA		CLARK	(SVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					needed.			
					III. System in place:	-4		
					The nursing team will be eduction of meal	aled		
					percentages and how to moni	tor		
					the completion of documentat			
					Date of education	J.1.		
					10/16/24-10/24/24			
					Nursing staff was educated or	1		
					Meal documentations on			
					10/16/24-10/24/24			
					IV. How the facility will			
					monitor and Quality Assurar	ice		
					program:			
					The CNA's will document the			
					consumption after each meal,	the		
					floor nurses will run a meal	and		
					consumption report before the of each shift, the DON or desi			
					will audit the meal consumption	-		
					report everyday x 1 week ther			
					weekly x 4 weeks, then month			
					4 months	.,		
					The facility will monitor meal			
					consumption documentation.			
					Should concern(s) be identifie	d,		
					immediate corrective action st	nall		
					be taken.			
					The DON or designee will aud			
					meal consumption report ever			
					x 1 week then weekly x 4 wee	KS,		
					then monthly x 4 months	noo		
					The Director of Nursing/Desig will provide the results from the			
					audits to the Quality Assurance			
					Performance Improvement	J		
					Committee (QAPI). These find	linas		
					will be reviewed for	90		
					recommendations by the Qua	lity		
					Assurance Performance	,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	A. BUILDING <u>00</u>		COMPLETED		
155191		B. WING	B. WING 10/15				
			<u> </u>	STREET ADDRESS (	CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		2210 GREENTR			
WESTMINSTER VILLAGE KENTUCKIANA  (YA) ID SUMMARY STATEMENT OF DEFICIENCIE				CLARKSVILLE,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		CROSS-F	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		rag .	DEFICIENCY)		DATE
F 0842 SS=D	483.20(f)(5), 483.	70(i)(1)-(5) - Identifiable Information		These for comple to QAP months provide as need or facility a for 4 control will be recoording.	ement Committee (QA findings and review will sted monthly and submitted monthly and submitted monthly and four so the Committee will be guidance for further added. The QAPI team whose a month until the attains 100% compliant prector of Nurses/Designesponsible for the lattion and monitoring.	Il be uitted action vill	
Bldg. 00	Based on interview failed to ensure residecumented, per the residents reviewed B and Resident C)  Findings include:  1. The clinical record on 10/11/24 at 12:2 included, but were rechronic obstructive depression.  The care plan, dated required setup assist monitor/document procession.	and record review, the facility dents meal consumptions were e plan of care, for 2 or 3 for medical records. (Resident rd for Resident B was reviewed 7 p.m. The resident's diagnoses not limited to, dementia, pulmonary disease and	F 084	correct allegati facility desk re complie The fili correct that the in fact correct of the f comply require provide Plan of I. resider	accept this plan of tion as our credible ion of compliance. The respectfully requests eview to determine ance.  In gof this plan of tion does not constitute alleged deficiency dexist. This Plan of tion is filed as evident facility's desire to y with the regulatory ements and continue to equality care.  If Correction F 842  Action taken for those ints identified:  Int B and C. Resident in the complex contents identified:	s a ute lid ce to	10/25/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155191	B. WING			10/15/2024	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				REENTREE N		
WESTMI		TAITHOULANIA					
WESTIVII	NSTER VILLAGE K	ENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	consumptions were	not documented on the			meal consumptions are being		
	following dates:				documented and audited. C.N	I.A.	
					and Nursing staff have been		
	- On 8/01/24, the re	sident's consumption for			re-educated to document mea	I	
	dinner was not docu	imented.			consumption. Resident C no		
	- On 8/02/24, the re	sident's consumption for			longer resides at Westminster.		
	dinner was not docu	mented.			Resident B and C did not		
	- On 8/05/24, the re	sident's consumption for			experience any adverse reacti	ons.	
	dinner was not docu	mented.			II. How other residents a	re	
	- On 8/06/24, the re	sident's consumption for			identified:		
	dinner was not docu	imented.			An audit of residents' meal		
	- On 8/07/24, the re	sident's consumption for lunch			documentation was completed	lon	
	was not documented				10/23/24 for documentation of		
	- On 8/09/24, the re	sident's consumption for			meal consumptions. Any issue	es	
	dinner was not docu	imented.			identified of records lacking		
		sident's consumption for			documentation of the meal		
		were not documented.			consumption were addressed	if	
		sident's consumption for			needed.		
		were not documented.			III. System in place:		
	- On 8/18/24, the re	sident's consumption for lunch			The nursing team will be educ	ated	
	was not documented				on documentation of meal		
		sident's consumption for			percentages and how to monit		
		were not documented.			the completion of documentati	on.	
		sident's consumption for			Date of education		
	breakfast and lunch	were not documented.			10/16/24-10/24/24		
					Nursing staff was educated on		
	_	ember 2024 meal consumption			Meal documentations on		
		resident's following meal			10/16/24-10/24/24		
		not documented on the			IV. How the facility will		
	following dates:				monitor and Quality Assuran	ce	
	0.0/00/04 4				program:		
		sident's consumption for			The CNA's will document the r		
		were not documented.			consumption after each meal,	tne	
		sident's consumption for			floor nurses will run a meal		
	oreakiast and lunch	were not documented.			consumption report before the		
	Daning a Color	10/15/24 - 4 2/25 CNIA			of each shift, the DON or design	-	
	_	on 10/15/24 at 2:35 p.m., CNA			will audit the meal consumptio		
		Aide) 5 indicated all resident			report everyday x 1 week then		
	meais should be doo	cumented in the system.			weekly x 4 weeks, then month	ıy x	
					4 months		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  10/15/2024					
	NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE KENTUCKIANA  ON UP SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI					
PREFIX TAG	REGULATORY OF  2. The clinical record on 10/11/24 at 1:20 included, but were redepression and left hemiparesis.  The care plan, dated resident required set to monitor/document.  Review of the Aug record indicated the consumptions were following dates:  - On 8/01/24, the redinner was not document was not document.	et LSC IDENTIFYING INFORMATION and for Resident C was reviewed p.m. The resident's diagnoses not limited to, dementia, sided hemiplegia and and at 10/21/22, indicated the trup assistance will meals and ant percentage eaten.  The resident's following meal not documented on the sident's consumption for amented.  Sident's consumption for lunch d.	PREFIX TAG	The facility will monitor meal consumption documentation. Should concern(s) be identificing immediate corrective action is be taken. The DON or designee will aumeal consumption report every x 1 week then weekly x 4 week then monthly x 4 months. The Director of Nursing/Design will provide the results from the audits to the Quality Assurant Performance Improvement Committee (QAPI). These fin will be reviewed for recommendations by the Quality Assurance Performance Improvement Committee (QAThese findings and review with completed monthly and submatted to QAPI for a period of four months. The Committee will provide guidance for further actions.	ed, shall dit the ryday eks, gnee ne ce dings ality API). Il be nitted				
	- On 8/09/24, the redinner was not docuted - On 8/11/24, the redinner was not docuted - On 8/12/24, the redinner was not docuted - On 8/14/24, the reduced - On 8/15/24, the reduced - On 8/15/24, the reduced - On 8/25/24, the reduced - On 8/30/24, the r	sident's consumption for amented. sident's consumption for amented. sident's consumption for were not documented. sident's consumption for lunch		as needed. The QAPI team were once a month until the facility attains 100% compliar for 4 consecutive months. The Director of Nurses/Desig will be responsible for the coordination and monitoring.  Date Complete 10/25/24	vill				

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l l		X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPLETED	
		155191	A. BUILDING 00  B. WING			10/15	/2024
NAME OF F	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD		
					REENTREE N		
WESTMI	NSTER VILLAGE K	KENTUCKIANA	CL/	\RK	SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`		PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY		DATE
		not documented on the					
	following dates:						
	- On 9/02/24, the re	esident's consumption for					
		were not documented.					
	- On 9/03/24, the re	esident's consumption for					
	breakfast and lunch	were not documented.					
		esident's consumption for					
		were not documented.					
		esident's consumption for					
	dinner was not docu						
		esident's consumption for					
		were not documented.					
		esident's consumption for					
	breakfast, lunch, an	d dinner were not					
	documented.						
		esident's consumption for					
	dinner was not doct						
		esident's consumption for					
	dinner was not docu						
		esident's consumption for lunch					
	and dinner were no						
		esident's consumption for					
	breakfast, lunch, an documented.	id dhiller were not					
		esident's consumption for					
		were not documented.					
		esident's consumption for					
		were not documented.					
		esident's consumption for					
	dinner was not doci	_					
		esident's consumption for lunch					
	was not documente	•					
		esident's consumption for					
	dinner was not docu						
	D	120241					
		bber 2024 meal consumption					
		e resident's following meal					
	following dates:	not documented on the					
1	I TOHOWING GAICS:		1				1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/15/2024	
	ROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
	breakfast, lunch, and documented.  On 10/02/24, the representation of the purpose	resident's consumption for were not documented. resident's consumption for dinner were not resident's consumption for amented. resident's consumption for were not documented. resident's consumption for mented. resident's consumption for were not documented.  26 a.m., the Director of Nursing ropy of the document titled d). Unplanned Weight Loss - ated 9/2017. It included, but "The nursing staff" dietary intake of residents in mits comparisons over time"			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155191	B. WING			10/15/2024		
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE KENTUCKIANA			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
	This Citation relates 3.1-50(a)(1)	s to Complaint IN00442568						

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